Advanced Chiropractic Relief

Dr. Gregory E. Johnson, D.C.

363 N Sam Houston Pkwy E Suite 1100

Houston, Texas 77060

RELEASE OF MEDICAL/CHIROPRACTIC RECORDS

DATE: ___/___/___

TO: _____

PHONE: (_____)_____-_____

FAX: (_____)_____-_____

FROM*: Dr. Gregory E. Johnson, D.C.*

PHONE: (281) 405-2611

FAX: (281) 405-2631

RE: ALL MEDICAL RECORDS FOR _____(PATIENT NAME)

SOCIAL SECURITY #: _____/_____/_____

I, _____,(PATIENT NAME) request and consent to the release of the following information:

____X-Rays ____History _____Diagnosis _____Treatment ____Any & All Reports _____Diagnostic Testing Reports/Results

____Date of Accident If Any-_____/_____/_____

____Any care given at your facility

Sent to: **Dr. Gregory E. Johnson, D.C./Advanced Chiropractic Relief**

Address: 363 N Sam Houston Pkwy E Suite 1100

Houston, Texas 77060

For the purpose of Medically Necessary treatment at this office.

Patient Signature: _____ Date:___/___/___

I certify that the protected health information of the above referenced patient will be used solely for the purpose of treatment, payment and operations. This facility complies with all applicable federal and state privacy statues.

Witness: _____ Date: ___/____/_____